Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services

☐ **Initial**
☐ **Annual**
☐ **Modification**

PLAN OF CARE/ PRIOR AUTHORIZATION FOR HCB WAIVER SERVICES

☐ **Traditional**
☐ **CDO**
☐ **Blended (CDO/ Traditional)**

1. Recipient Name: _____ SSN: _____
(Last) (First) (MI)
MAID:_____

Address _____Phone:(__)_____
(Street, City, State, Zip Code)

2. Representative Name (CDO Only)_____ Phone:(__)_____

3. Diagnosis (es): _____

4. This Plan of Care covers the following period _____to _____

5.

NEED(S)	GOAL(S)	INTERVENTION(S)	OUTCOME(S)

6.

Requested HCBW Services:	Revenue Code	Frequency/Duration:	Units of Service:	Dollar Amount:	QIO to Complete Medicaid Action
					☐ Approved ☐ Denied
					☐ Approved ☐ Denied
					☐ Approved ☐ Denied
					☐ Approved ☐ Denied
					☐ Approved ☐ Denied
					☐ Approved ☐ Denied
					☐ Approved ☐ Denied

7. HCBW Provider Name: _____ Provider #: _____

   HCBW Provider Address (Street, City, Zip)_____ Phone: (____) _____

8. ADHC Provider Name: _____Provider #: _____

   ADHC Provider Address (Street, City, Zip)_____ Phone: (____) _____

9. Support Broker Name (CDO or Blended Only):_____ Phone: (____)_____

10. PHYSICIAN, PA OR ARNP STATEMENT: "I certify this individual, who is under my care, meets Nursing Facility Level of Care in accordance with 907 KAR 1:022. If Home and Community Based Waiver Services were not available Nursing Facility placement would be imminent. I have reviewed this Plan of Care in accordance with 907 KAR 1:160."

    Full Name (Print) _____ License #: _____

    Address_____

    Signature _____ M.D., P.A., A.R.N.P. Date: _____

11. Total Estimated HCBW Monthly Cost: $ _____Date Plan of Care Developed: _____

12. I certify the information contained above is accurate:

    Case Manager Signature:_____

    _____Date: _____

    Recipient's/Representative's Signature: _____ Date: _____

13. QIO Signature/Title: _____ Date: _____

SUPPORT SPENDING PLAN (CDO or Blended Only)

14. Benefit Total Requested _____ Start Date_____

15. Direct Employment

	Service Description	Employee Name	Hourly Wage	# Hours per month	Monthly Pay	Taxes	Monthly Amount
a)							
b)							
c)							
d)							

Total Monthly

Amount _____

16. TOTAL MONTHLY BENEFIT REQUEST: _____ START DATE: _____

17. Emergency Back-up Plan

_____

_____

_____

_____

_____

_____

_____

Recipient's/Representative's Signature: _____ Date: _____

Support Broker Signature_____ Date: _____

Support Spending Plan (Sections 11-15) **Approved**_____ **Denied**_____

QIO Signature/Title: _____ Date: _____